BRIEF

ATTITUDES OF MEDICAL STUDENTS AND FAMILY PRACTICE RESIDENTS TOWARD GERIATRIC PATIENTS

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The federal government, as well as teaching institutions, are concerned about the current negative attitudes of doctors, medical students, and paramedical personnel toward the elderly. Increased life expectancy at birth and lowered birth rates are changing the demographics of America. As the number of elderly citizens increases, greater demands are being placed on medical educators to train physicians who can meet the "geriatric imperative." The Institute of Medicine has recommended that comprehensive humanistic medical education in geriatrics be integrated throughout the curricula of medical schools. Research is needed to see if change can be implemented in physician training to improve attitudes toward the elderly. Previous attempts to improve medical students' attitudes toward the elderly have met with mixed success. Control groups have seldom been used. It is important to determine whether the effects of medical education extends beyond the immediate boundaries of a training curriculum. This article reports the results of a study on negative attitudes toward the elderly among residents, medical students, and physician's assistant students in the family medicine department at the King/Drew Medical Center in Los Angeles, California. (*J Natl Med Assoc.* 1993;85:61-64.)

Key words • elderly • attitudes • medical students • residents

The "graying of America" is constantly on the minds of everyone. In 1900, there were less than 3 million Americans over the age of 65. Today, there are more than 30 million, and in the next 25 to 30 years this number will increase to 40 or 50 million. Additionally, there are 12 million elderly over the age of 75—3 million of these are over the age of 85.[7] Life expectancy has been increasing for most Americans. Unfortunately, for African-American males, life expectancy has decreased slightly over the past 2 years.

As of 1988, there were 2 million African Americans over 55—1 million over the age of 65 and approximately 900 000 over the age of 75. The elderly is currently the fastest growing segment of the African-American population, as well as the general population in America, and those over the age of 85 are leading the pack.[10]

Not only are the demographics of America changing, but the general characteristics of the elderly are also changing. The elderly are, and will be, healthier, better educated, and more demanding, vigorous, aggressive, independent, organized, and self-reliant.[1] They will not sit back and accept second-class citizenship and inferior medical treatment. They will demand to be heard, ask questions, and expect fair treatment. Because they are banding together and voting as a block, politicians today are afraid of the power of the aged as demonstrated by the repeal of the new Social Security laws in

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TABLE 1. CHARACTERISTICS OF RESPONDENTS*

	No.
Medical students	49
3rd year	26
4th year	23
Physician's assistant students	12
Family practice residents	18
1st year (interns)	6
2nd year	6
3rd year	6

*N = 79.

1989. Doctors will learn to respect the elderly or end up with a reduced patient load or in malpractice suits. Most Americans know of the existence of the Grey Panthers and their aggressive, demanding platforms for elderly citizens in this country.

BACKGROUND

The Flexner Report was concluded in 1910, resulting in more classroom instruction and the cessation of "apprenticeships." A standardized training program was begun to improve medical training, and a majority of inferior medical schools were forced to close their doors in America.

With World War II came technological gains that increased the view that medical care was cure-oriented. Acute care, with its immediate feedback, was the order of the day. Geriatric medicine tends to treat chronic and incurable conditions. It is no wonder that as late as 1977, an American Medical Association survey found that only 0.2% of responding physicians indicated that geriatrics was of interest to them. The 1970s found only 15 medical faculty members out of 22 000 who were specifically involved in teaching geriatrics.

The 1980s brought forth a new interest in geriatric medicine. Prior to this, older general practitioners were the only ones interested in elderly patients—older doctors were treating the older patients. Suddenly, many physicians, not just the family physician or internist, began to get involved with older patients. This included younger practicing physicians and recent graduates from residency programs. In fact, 42% of elderly patients see other specialists today. This was necessitated by the fact that 30% of all office visits and 40% to 50% of all hospital visits were for the older patient. Subspecialists were forced to jump on the bandwagon for survival. Twenty percent of the clientele of neurologists, general surgeons, urologists, and ophthalmologists are the elderly. Geriatric patients account for almost 50% of the cardiologists' patients and 30% to 40% of the psychiatrists' patient load.[10]

Geriatric training is beginning to be seen not as a luxury, but as a necessity for the survival of all of us in our practices. Currently, there are 175 to 300 full-time faculty members in geriatrics. Approximately 500 physicians have completed fellowship training in geriatrics. Ninety percent of all of the 123 medical schools in America offer some type of geriatric training. Fifteen percent have geriatric clinical training in the following departments: family medicine, internal medicine, and psychiatry. However, 18% have no clinical programs, and only 2.3% of all third- and fourth-year medical students take geriatric electives. There is only one department of geriatric medicine in a medical school in America. The others are "divisions," usually in the internal medicine department. Fellowship training has also expanded. In internal medicine, the number of geriatric fellowship programs has risen from 36 in 1980 to 103 in 1987. Family medicine has lagged behind with only two programs in 1983 and 16 as of 1988. Geriatric psychiatry fellowships have increased from 11 programs in 1980 to 29 in 1987.

Teaching geriatric medicine to clinical trainees has only occurred recently. It wasn't until the 1960s that geriatric medicine was introduced to medical students. There are several reasons for this omission: lack of experienced faculty, lack of applicants for fellowship positions, competition for already overcrowded curriculum time, inadequate funding, and unwillingness to give up curriculum time by established disciplines (turf).[2]

MATERIALS AND METHODS

A questionnaire consisting of 50 true-or-false questions regarding attitudes toward the elderly was administered to medical students and physician's assistant students at the Drew University School of Science and Medicine and family practice residents at the Drew/King Medical Center, Los Angeles, California (Table 1). The questionnaire was modeled after the revised version of "Facts on Aging."[6]

A total of 79 questionnaires were completed. The ages of the respondents ranged from 23 to 30. Students came from a variety of socioeconomics backgrounds, races, and ethnic groups.

Many of the questions on the survey were common myths regarding older people. A score of 50 or more was considered "positive knowledge" (liked) and less than 50 was scored as "negative knowledge" (disliked) (Table 2).

DISCUSSION

These data indicate that the more training and exposure the medical students and residents had to the elderly, the more they disliked them, even though the students may have known more facts about their social, economic, medical, and psychological states. This study, however, was inconclusive and left many unanswered questions. First, a number of people influenced the outcome of the study such as teachers, role models, paramedical personnel, etc. Some had positive attitudes and others had negative attitudes regarding the elderly because of previous exposure or training (or lack of training). It is possible that some students and residents were unhappy that more materials were added to their already crowded curriculum. Many may have been influenced by experiences they had with relatives in their homes. Some may still strongly believe in existing myths about the aged, and some suffer from "ageism."

The future medical curriculum planners and department heads will probably not want changes in existing time schedules allocated to them. All medical educators will agree, however, that gerontology and geriatric medicine need to be studied and included in medical education, but few will want to sacrifice time or energy in that direction.[2]

It was no accident that this study focused on medical students and family practice residents, because it has been axiomatic that the family physician produced by training programs must combine clinical excellence with compassion and humaneness. There are many educators and medical school admission committees who believe that there will be opportunities that should be grasped to compare students who are attracted to comprehensive medicine, and do well in it, with students who prefer and excel in the other specialties. It is quite possible that comprehensive medicine will have greater appeal to the more humanistically inclined students and to those who prefer the behavioral sciences, while those who find greater satisfaction as undergraduates in physics, chemistry, or biology are more likely to want to enter the traditional specialties. If such differences can be confirmed in future studies, the implications for admissions policies to medical schools and residency training programs would be numerous.

For too long, the attitude toward the elderly has been that they are sick, depressed, unproductive, inflexible, dependent, eccentric, and unpleasant people—a stereotype that Robert Butler, the former director of the National Institute on Aging, called *ageism.* Studies

TABLE 2. PERCENTAGE OF QUESTIONNAIRE RESPONDENTS WHO LIKED OR DISLIKED THE ELDERLY

	Liked	Disliked
Medical students		
3rd year	71%	29%
4th year	63%	37%
Physician's assistant students	83%	17%
Family practice residents		
1st year	47%	53%
2nd year	45%	55%
3rd year	42%	58%

indicate, however, that students and residents can be influenced significantly by their clinical rotations and role models in the medical school and hospital settings, and the potential for communicating positive orientations toward the treatment of the elderly and toward chronic illnesses does exist.[3]

Although training in geriatric medicine is expanding and interest in geriatric programs is increasing, the demand for well-trained physicians will be even greater in the future. The need for pure academic geriatricians will go as high as 2000 by the turn of the century. If geriatricians provide more than just teaching services, such as consultation and limited primary care, the need for such physicians would rise to an estimated 29 000.[4]

Geriatric medicine for the future will highlight chronic diseases and syndromes, focus on long-term institutions, and direct diagnostic and therapeutic efforts to individuals who do not subscribe to one of the traditional specialties. There is little doubt that medical professionals have often in the past (and some still do) viewed the elderly as deteriorated, dependent, rigid, and resistant to medical treatment.

There is hope that students entering medical school today will become more resistant to negative images of the elderly. Many researchers believe that the critical period for changes to less favorable attitudes toward the elderly may well occur later in medical education. This may be due to their contact with the elderly in tertiary-care medical centers or in skilled nursing facilities for long-term care in the their clinical years. These unfavorable environments help to distort views of the health status of older people.[9] Again, perhaps the optimal time for behavioral science training in geriatrics is in the first year of medical school before attitudes toward the elderly start to become negative.

This early training period should begin with factual information about the situation of the elderly. Students

should be exposed to elderly individuals at different levels of health. Their experiences with the elderly should then be discussed with both clinical role models and other students.[8]

Finally, improved attitudes toward the elderly may not last if they are not reinforced by the students' peers and faculty role models. Medical educators must prepare students and residents for the demographic transition in the American population. For teachers and role models in the community to have an impact on changes in attitude of these young budding physicians, they too must improve their expertise by taking formal courses in geriatrics and gerontology. Such exposure will influence changes in their personal attitudes and in their future experiences with the elderly.[5]

Further studies need to be conducted to verify these findings and shed further information on this important topic.

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